Health, Welfare Public Service

300
1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-011970
STATE FILE NUMBER

FILED APR 3 1959 Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 52

1. PLACE OF DEATH
a. COUNTY: Scott
b. CITY OR TOWN: Sikeston — Inside Limits: Yes ☐ No ☐
c. FULL NAME OF HOSPITAL OR INSTITUTION: Mo. Delta Comm. Hosp. — Length of stay in 1b: 4 Days

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: New Madrid
c. CITY OR TOWN: Matthews 0720 — Inside Limits: Yes ☐ No ☒
d. STREET ADDRESS (If outside, give location): Route #1 — Reside on Farm: Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First PEARL Middle LEOA Last McROY
4. DATE OF DEATH: Month 3 Day 20 Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 24, 1896
9. AGE (In years last birthday): 62 — IF UNDER 1 YEAR: Months 9 Days 26 — IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: ------
11. BIRTHPLACE (City and state or country): Rockport, Ind.
12. CITIZEN OF WHAT COUNTRY? US
13a. FATHER'S NAME: William Holden
13b. MOTHER'S MAIDEN NAME: Sarah Ellen McCulough
14. NAME OF HUSBAND OR WIFE:
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: +93-36-+392
17. INFORMANT Address: Mrs. Lorene Higgerson, New Madrid, Mo

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma of Breast — INTERVAL BETWEEN ONSET AND DEATH: about 3yrs
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): 170X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 3-17-59, to 3-20-59 and last saw her him alive on 3-20-59
Death occurred at 5:55 A. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Albert Sargent MD
22b. ADDRESS: Sikeston, Mo.
22c. DATE SIGNED: 3-21-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 22 March 59
23c. NAME OF CEMETERY OR CREMATORY: Memorial Parks
23d. LOCATION (City, town or county) (State): Sikeston, Mo.

24. FUNERAL DIRECTOR: Richards Undt Co. ADDRESS: New Madrid Mo.
25. DATE RECD. BY LOCAL REG.: 3-26-59
26. REGISTRAR'S SIGNATURE: Mrs Ella Hunter

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed Tommy L. Doherty

Licensed Embalmer No. 4886

P. O. Address New Madrid,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.